2 Month Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____

Developmental Screen: Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?) Yes _____ No _____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No ____

PHYSICAL EXAM

Are the following normal?	**Yes**	**No**	**Describe abnormal findings:**
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision (red reflex)			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			
13. Hemoglobin/Hematocrit (perform at 1-9 mos of age)			

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** ____ **Delayed?** _____ **Deferred?** _____

Given today? Hep B ____ **DTaP** ____ **Hib** _____ **IPV** ____ **PCV** ____ **Other** _____

ANTICIPATORY GUIDANCE

- Supine sleep position
- Signs of illness
- Injury prevention
- Emergency/911
- Drowning prevention
- Passive smoke
- Car seat
- Dental gum care/bacteria
- Postpartum Adjustment
- Parenting Practices
- Family involvement
- Infant bonding
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004